Behavioral Health Preauthorization Request Form

PacificSource

Please return to:
PacificSource
Attn. Health Services
Fax: (541) 225-3667

Instructions:
1. Please complete all of the form. Missing information will delay the preauthorization process.
2. **Include clinical information** and fax to (**541) 225-3667**

Please note:
- Requests received after 3:00 p.m. will be processed the next business day.
- You can expect to receive a response within two business days.
- We will mail or fax a determination notice to the requesting provider, facility, and patient.
- **An intake assessment is required within 72 hours of admission**.

If you have any questions, please feel free to contact us at (541) 684-5584 or toll-free at (888) 691-8209.

▼ PATIENT

Last name: _____ First name: _____

Date of birth: _____ Member ID number: _____

▼ SERVICES

Type of service: _____

Diagnosis code and description: _____

☐ Inpatient **admission date:** _____ ☐ To be scheduled Estimated length of stay (days): _____

☐ Residential **admission date:** _____ ☐ To be scheduled Estimated length of stay (days): _____

☐ Partial Hospitalization Program (PHP): Hours per day _____ x days per week _____ = total hours _____

PHP start date: _____ End date: _____

☐ Intensive Outpatient Program (IOP): Hours per day _____ x days per week _____ = total hours _____

IOP start date: _____ End date: _____

Retrospective review? ☐ Yes ☐ No Dates of service: _____

▼ PROVIDER CONTACT INFORMATION

Contact person:

Name: _____ Date: _____

Phone: _____ Extension: _____ Fax: _____

Attending/ treating provider:

Name: _____

Phone: _____ Extension: _____ Fax: _____

Address: _____ City/State/Zip: _____

TIN: _____ NPI: _____

Facility/place of service:

Name: _____

Phone: _____ Extension: _____ Fax: _____

Address: _____ City/State/Zip: _____

TIN: _____ NPI: _____